STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING _____ B. WING _____	R-C 09/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for the Post Survey Revisit (PSR) to the investigation of Complaints IN00133670 and IN00134323 completed on 8/15/13.

This visit was in conjunction with the PSR to the Recertification and State Licensure Survey completed on 7/19/13.

Complaint IN00133670-Corrected.
Complaint IN00134323-Corrected.

Survey dates: September 16 &,17, 2013

Facility Number: 000098
Provider Number: 155187
AIM Number: 100290980

Survey Team:
Heather Tuttle, R.N. T.C.
Yolanda Love, R.N.

Census Bed Type:
SNF/NF:146
Total: 146

Census Payor Type:
Medicare: 28
Medicaid: 98
Other: 20
Total: 146

Golden Living Center-Fountainview Place was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaints IN00133670 and IN00134323.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING _____ B. WING _____	R-C 09/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	**3175 LANCER ST PORTAGE, IN 46368**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Quality review completed on September 22, 2013, by Janelyn Kuklik, RN.	{F 000}		